Disability payments stabilizing after era of accelerating growth

Programs' share of GNP was constant at 2.2 percent in 1975–77, with claims dropping from peak rates of the mid-1970's; since 1950, payments under both private and Government plans had mushroomed

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Considerable evidence since 1975 suggests that the previous rapid expansion of disability cash benefits has ceased. Overall, these programs' share of the Gross National Product (GNP) was constant rather than growing between 1975 and 1977, the latest year for which comprehensive data are available. (See table 1.)

The growth rate of real per capita benefits, one of the two factors that determine the growth of total expenditures, seems to have slackened during this period. (See table 2.) One likely cause is the increasing number of Federal programs in which benefit adjustments are provided through systems of automatic indexing tied to wages or prices. Social Security Disability Insurance (DI), for example, is tied to the Consumer Price Index. These adjustment mechanisms have increasingly replaced special, individually legislated adjustments which often provided increases greater than those in wages or prices.

Regarding numbers of beneficiaries, the other factor that determines total expenditures, most evidence also points to a recent slackening of growth. Claims rates are down in many major programs. For example, DI claims rates have declined substantially from their 1974 peak, which had been caused by greater public awareness of the program. The decline was a generally continuing phenomenon over the subsequent five years, and the annual claims rate is now 13 per 1,000 insured workers, as compared to the 1974 peak of 16 per 1,000. Likewise, Federal Civil Service disability retirement awards, after increasing from 8 per 1,000 insured workers in 1965 to a peak of 12 per 1,000 during 1975–77, declined to 9 per 1,000 by 1979. Here, a tax law change was probably largely responsible. The change reduced the after-tax advantage of receiving disability benefits rather than regular retirement benefits. New Supplemental Security Income (SSI) disability awards have also been declining while the poverty population, one rough index of the underlying pool of possibly eligible persons, has been stable. New SSI disability awards decreased from approximately 370,000 in 1976 and 1977 to approximately 325,000 in 1979. Most dramatically, the number of DI beneficiaries, after very rapid increases since the program's inception, has remained largely constant since 1977 and has actually declined slightly since late 1978.

The growth period

In contrast, after remaining a fairly constant percentage of GNP for many years, cash payments to disabled persons began a period of rapid growth during the mid-1960's, as table 1 shows. During 1965–75, they increased from $9.7 billion or 1.4 percent of GNP, to $33.9 billion or 2.2 percent of GNP.

Several related developments added to the concern generated by this decade of intense growth in cash payments. For one, medical payments for the disabled were

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about twice as large as cash payments and grew as rapidly.[1] Second, the Federal share of cash disability payments rose significantly, from 55 percent in 1965 to 61 percent in 1975, as table 1 indicates. Third, the number of beneficiaries of some of the largest programs grew dramatically. (See table 3.) For example, beneficiaries of DI, the largest single disability program in the Nation, increased by 150 percent, from 1 million to 2.5 million, during 1965–75, while the covered workforce grew by only 55 percent. Simultaneously, Federal Civil Service disability retirement rolls grew by nearly 75 percent, while the covered workforce remained essentially constant. And the number of persons on the disability component of the welfare rolls increased by 140 percent during 1963–73 despite a substantial decline in the poverty population.[2] Fourth, the proportion of the population reporting itself as disabled grew substantially. For example, National Center for Health Statistics (NCHS) data show that between 1969 and 1978 the proportion of men age 45–64 reporting themselves unable to work increased from 72 per 1,000 to 101 per 1,000, an increase of 40 percent.[3]

Such developments led to a number of public policy responses. The responses ranged from including disability as a major item on the agenda of the President's Commission on Pension Policy (1979–81), to passing 1980 amendments to the Social Security Act, intended to increase incentives for DI beneficiaries to return to work. These amendments in some cases reduced allowable DI cash benefits.

Because of concerns about the recent rapid growth in cash disability payments, the analyses reported in this article were undertaken to identify the underlying causes. Because concern for the future is as serious as concern about what has happened to date, this study also examines the most recent trends in disability programs as a basis for judging both the current situation and the probable future course of disability payments.[4]

Two sources of increase

Purely as a matter of arithmetic, increased disability expenditures must stem from either increased per capita benefits, increased numbers of beneficiaries, or a combination of the two.

Per capita benefits. Increased real per capita benefits have been an important source of the growth in disability cash payments. Table 2 shows the annual growth rate of real per capita benefits in programs for which data are available. It also provides comparison series on workers' real spendable earnings and real per capita GNP.[5] Per capita benefits have generally grown more rapidly than earnings, with the disparity being particularly great in the first half of the 1970's. As a rough estimate, disability cash payments in 1975 would have been less than three-fourths of their actual level had per capita benefits merely kept pace with, rather than exceeded, the growth in earnings since 1950. However, two points about the growth in per capita benefits should be noted. For one, benefit increases have usually

Table 1. Disability transfer payments in millions of dollars, 1950–77

Program	1950	1955	1960	1965	1970	1975	1977
Grand total	3,094	4,672	6,603	9,729	17,140	33,865	42,230
Grand total as percentage of GNP	1.1	1.2	1.3	1.4	1.7	2.2	2.2
Work-caused disability							
Subtotal	360	521	755	1,074	1,751	3,822	4,946
State workers compensation	$347	$503	$730	$1,038	$1,590	$2,855	$3,805
Federal Employees Compensation Act (FECA)	13	18	25	36	84	375	570
Black Lung	0	0	0	0	77	592	571
Workplace-based long-term disability							
Subtotal	1,516	1,994	3,010	4,749	8,231	17,911	22,747
Social security disability insurance	0	0	568	1,573	3,067	8,414	11,463
Federal civilian employees disability retirement	41	71	152	279	518	1,307	1,847
Military disability retirement	149	209	244	318	538	906	1,023
Veterans compensation	1,175	1,440	1,570	1,765	2,555	4,010	4,794
State and local government employees disability retirement	24	55	95	155	255	490	630
Private sector long-term disability insurance	(1)	(1)	(1)	7[3]	115[3]	500[2]	540[2]
Private sector disability retirement	50[3]	116[3]	234[3]	503[3]	964[3]	1,881[3]	1,995[3]
Railroad programs	77	103	147	149	219	403	455
Workplace-based short-term disability							
Subtotal	932	1,629	2,296	3,207	5,695	8,166	9,758
Private sector short-term disability insurance (including State-mandated coverage)	293	551	810	1,037	1,887	2,548	2,926
Private sector sick leave	180	273	400	566	1,066	1,789	2,357
Federal civilian employees sick leave	172	269	348	488	786	1,019	1,343
State and local government employees sick leave	143	276	478	776	1,416	2,220	2,522
Military sick leave	144[2]	260[2]	260[2]	340[2]	540[2]	590[2]	610[2]
Non-workplace-based, public assistance type							
Subtotal	286	528	542	699	1,463	3,966	4,779
Welfare for disabled and blind, later SSI	61	203	322	494	1,073	3,276	3,856
Veterans pensions	225[3]	325[2]	220[2]	205[2]	390[2]	690[2]	923[2]
	In percent						
Composition of total							
Federal	65	60	56	55	54	61	63
State and local	18	20	22	23	22	19	19
Private	17	20	22	22	24	20	19

[1] Less than $500,000.
[2] Figure approximate.
[3] Figure highly approximate.

SOURCE: Jonathan Sunshine, "Disability", U.S. Office of Management and Budget Staff Technical Paper, 1979, pp. 29–30, and updates thereto.

Table 2. Rate of growth of real per capita disability benefits, 1950–77 (compound annual growth rate of constant dollar amounts)

[In percent]

Program	1950–60	1960–70	1970–75	1970–77
Social Security Disability Insurance	...	2.3	3.5	3.2
Federal civilian employees disability retirement	2.5	3.7	5.5	3.8
Military disability retirement	1.9	0.3	1.9	1.8
Veterans compensation	0.6	1.9	1.4	2.6
State and local government employees disability retirement	6.5	2.7	2.6	2.4
Railroad programs	2.0	1.5	4.3	1.2
Welfare for the disabled and blind, later SSI	4.1	1.7	1.9	1.0
Comparison				
Average nonsupervisory worker's spendable earnings	1.3	0.9	0.1	1.8
U.S. per capita GNP	1.9	2.7	1.5	4.5

SOURCE: Jonathan Sunshine, "Disability", U.S. Office of Management and Budget Staff Technical Paper, 1979, p. 41, and updates thereto.

been the deliberate result of legislation. Examples include the increase in veterans' compensation enacted in each of the last several years and the 20 percent increase in social security benefits enacted in 1972. Thus, most of the increase in per capita benefits should be recognized to be the result of deliberate policy decisions that benefits should increase. The second point is that the latest available data, as the last column of table 2 shows, are suggestive of a recent decrease in the growth rate disparity between wages and per capita benefits.

Thus, while growth in per capita disability benefits is clearly a major source of growth in total payments, analysis does not support any initial impression that the increase is both unintended and accelerating.

Number of beneficiaries. As already noted, the data show that the number of beneficiaries of some major programs has increased much more rapidly than the population the programs cover.

However, for at least two reasons, such findings do not necessarily reflect an underlying change. For one, they could conceivably reflect program start-up phenomena, which would be expected to run for many years. The program start-up possibility means that rates of influx of new beneficiaries are the best figures to examine in order to ascertain whether there has been a genuine, underlying change in the use of programs covering permanent disability. Second, the findings could reflect aging of the covered population, because the incidence of disability rises sharply with age. For example, Social Security Administration data from a 1972 survey show that the fraction of the population reporting itself unable to work either regularly or at all ranges from 2.2 percent among persons age 20–34 to 19 percent among those age 55–64. Because of the possible confounding effects of aging, data for each age and sex group should be examined separately. For DI and Federal Civil Service retirement, the two programs for which such analyses have been undertaken, the rate of disability awards for each age and sex group about doubled during 1964–74.[6] Thus, there clearly has been a genuine increase in the use of disability programs.

The central question—why the increase?

Health. In looking for the sources of this increased program use, the natural first question is whether people's health has deteriorated. If so, increased use of programs would be a simple reflection of poorer health status.

Evidence on this point is indirect, although generally negative. Mortality rates are down and life expectancy at various ages is up, suggesting that illnesses underlying disability probably have decreased also. But no hard data based on medical examinations are currently available.[7]

Moreover, it is possible that the improved mortality statistics reflect, in part, that people who formerly

Table 3. Disability transfer payment beneficiaries in thousands, 1950–77

Program	1950	1955	1960	1965	1970	1975	1977
Grand total[3]	(5)	(5)	(5)	(5)	(5)	10,200[4]	10,900[4]
Work-caused disability							
Subtotal[3]	(5)	(5)	(5)	(5)	(5)	500[5]	475[5]
State workers compensation	(5)	(5)	(5)	(5)	(5)	1,000[2]	(5)
Federal Employees Compensation Act (FECA)	15[4]	15[4]	15[4]	20[4]	25[4]	45	46[4]
Black Lung	0	0	0	0	25	333	298
Workplace-based long-term disability							
Subtotal[3]	2,269	2,492	3,065	3,779	4,708[4]	6,285[4]	6,700[4]
Social security disability insurance	0	0	445	988	1,493	2,489	2,834
Federal civilian employees disability retirement	43	61	102	149	185	258	301
Military disability retirement	56	86	90	108	148	163	158
Veterans compensation	1,990	2,076	2,027	1,992	2,091	2,220	2,244
State and local government employees disability retirement	32	42	55	69	86	128	152
Private sector long-term disability insurance	(5)	(5)	(5)	(5)	40	100	110[5]
Private sector disability retirement	72[5]	140[5]	239[5]	371[5]	570[5]	825[5]	800[5]
Railroad programs	76	87	97	102	95	102	100
Workplace-based short-term disability[1]							
Subtotal[3]	(5)	(5)	(5)	(5)	(5)	1,000[2]	1,050[5]
Non-workplace-based, public assistance-type							
Subtotal[3]	416[5]	685	695	893	1,324	2,454	2,712
SSI—Disability and blindness	166	345	476	642	1,016	2,024	2,207
Veterans pensions	250[5]	340[4]	219	197	308	430	505

[1] Figures available only for subtotal.
[2] Total beneficiaries during the year; all other figures refer to beneficiaries on the rolls at a single point in time.
[3] Because programs overlap, totals generally include some double counting.
[4] Figure approximate.
[5] Figure highly approximate or, if no figure presented, unknown.

SOURCE: Jonathan Sunshine, "Disability", U.S. Office of Management and Budget Staff Technical Paper, 1979, pp. 31, and updates thereto.

would have died, but now survive, are in poor health and seriously impaired condition. These survivors could be a source of increased disability in the U.S. population. Fortunately, a good test of this possibility is available. Heart disease is the one major, chronic, disabling, killer disease which has shown a clear and substantial decline in mortality. The age-adjusted death rate from heart disease, per 100,000, declined from 307 in 1950, to 286 in 1960, to 220 in 1975, and is still falling rapidly. Hence, if there has been a genuine increase in ill health underlying disability, it should be composed in substantial part of persons who 20 or 30 years ago would have died of heart disease, but who now survive and are disabled. Consequently, there should be a large increase in the percentage of the disabled whose condition is due to heart disease. The data, however, do not show such an increase. For example, NCHS data for 1969–76, a period when reported disability was rising rapidly, show that of persons age 45–64 and unable to carry on their usual major activities, the proportion incapacitated by heart disease remained stable at 20 percent among men and 10–15 percent among women. In addition, data from the Federal Civil Service retirement program show that the proportion of new disability awardees having cardiovascular disease declined from more than 40 percent in 1960 to 30 percent in the mid-1970's. During the same period, the rate of new disability retirement awards per 1,000 covered employees increased by more than 50 percent in this program, and the general heart disease death rate decreased by nearly 25 percent.

As the expected increase in disability from cardiovascular disease is not to be found, it thus seems extremely improbable that the increased use of disability programs results from poorer health.

An important distinction. What, then, are the causes? To understand them, it is necessary to draw a distinction, as specialists in the field of disability generally do, between impairment and disability. Impairment, the medical concept, means a physiological or mental loss or other abnormality. Disability, the social concept, means a health-related inability or limitation in performing roles and tasks expected of an individual in a social environment. The critical point is that, contrary to common assumptions, there is no one-to-one correlation between impairment and disability. For example, one person who loses the use of his legs may be unable to work, but another such person served for 13 years as President of the United States.

Among the factors that intervene between impairment and resulting disability for work are education, work experience, economic opportunity, and social and personal attitudes. Thus, someone with little education and literacy is likely to be employed in manual labor, which cannot be performed by a person having major physical impairments. On the other hand, jobs of persons with more education include and are probably dominated by chairbound posts, which often could be performed from a wheelchair, not only from a conventional chair. Factors intervening between impairment and disability make it possible for disability, the social phenomenon, to increase, while impairments, the underlying medical problem, do not.

Where is the answer found?

There is abundant evidence that two types of factors, economic and social, have played a major role in the increased use of disability programs.

Economic. Economic explanations of the increase hold that use of programs will depend upon how attractive the programs are, in a pecuniary sense, relative to alternatives. A number of analyses have been conducted using this framework and two types of economic variables have been stressed.[8] The first compares program benefits to earnings, providing an indication of how much income is offered by disability programs relative to the income available from the alternative of working. The replacement ratio (ratio of program benefits to past earnings) is the most commonly used such variable. The second type of variable, the unemployment rate, serves as a measure of the availability of the work option. Generally, economic analyses find both types of variable quite significant in explaining how many persons draw payments from disability programs. They find that the higher the benefits relative to earnings, and the higher the unemployment rate, the more people will make use of the programs. There is some tendency to find that the first type of variable, that which measures program benefits relative to earnings, is the most important. Studies from the private insurance industry, although simpler than the multivariable econometric analyses, show similar results.[9] Claims rates are almost one and one half times as high when replacement ratios are about 70 percent than when they are about 50 percent. And the increase in the claimed duration of disability episodes is even more dramatic.

Because of the economic effect of replacement ratios, increased per capita benefits raise disability expenditures in two ways, both directly through higher expenditures per beneficiary, and indirectly by inducing greater program utilization.

Social. Social factors have also played a very important role in the increased use of disability programs. Basically, the social explanation of the increase holds that it is becoming more socially acceptable to be disabled and that much of the growth in program use can be explained by subjective changes of attitudes and behavior, not by changes in "objective" circumstances, be they medical or economic. Three lines of evidence sug-

gest that this explanation indeed plays an important part in the changes that have occurred.

Three lines of evidence

More programs. First, American society has created new disability programs. Major examples include DI, created in 1956; Black Lung, created in 1969; the disability component of public assistance, begun late in 1950 and much expanded when federalized as Supplemental Security Income in 1974; and private long-term disability insurance, which was almost negligible as late as 1960. Although these four programs did not exist at the beginning of 1950, when this study began, by 1977 they paid out $16.4 billion per year, almost 40 percent of total disability cash payments. Thus, if society had not invented and funded new programs for disability since 1950, disability spending in 1977 would have been barely 60 percent as high as it was. Moreover, this figure is conservative because it neglects growth arising from the broadening of programs already in existence in 1950.

Changing attitudes. Second, the data that show more people identifying themselves as disabled, although impairments do not appear to have increased, suggest a private, individual parallel to the public, group change embodied in the creation of new programs. As more and more people label themselves "disabled," claims and awards under disability programs increase. This does not represent malingering unless one regards program definitions and operating procedures as inadequate; adequate program standards would reject unjustified claims. Rather, more persons who in previous years would have worked or attempted to, despite having disabilities which would have met program standards, now file disability claims and become beneficiaries.

The increase in the percentage of persons who identify themselves as disabled is occurring at all educational levels. The following NCHS data show the increasing percentage of men age 45–64 reporting themselves unable to perform their usual major activities:

Year	*Less than high school*	*High school graduate*	*More than high school*
1969	10.6	4.0	2.8
1974	15.1	5.4	3.5
1978	17.1	7.4	3.9

Awareness of programs. Third, information flows also affect benefit claims. Substantial portions of the disabled population have been unaware of disability programs. For example, in 1972, 16 years after the advent of DI, almost half of persons unable to work regularly or at all were unaware of the program. Moreover, a quarter of all persons this seriously disabled were unaware of any government disability program. Knowledge of disability programs among seriously disabled persons was scarcely better than among the nondisabled.[10]

The dissemination of information beyond the limited base represented by these figures has probably contributed to increased program use. The clearest example occurred in 1974 when welfare for the disabled and blind was federalized. The new Federal program, SSI, was thereafter administered by the Social Security Administration, which also administers DI. There was a sharp, temporary peak in DI claims and awards as welfare and SSI beneficiaries became more aware of DI, a program operated by the same office they now found themselves dealing with. They applied for DI in very large numbers and qualified in many cases.

In short, disability programs may have repeated the "welfare crisis" of the 1960's. In that crisis there was a dramatic increase in the number of beneficiaries, mainly reflecting a growing percentage of eligible persons filing claims. The total number of eligible persons remained relatively unchanged.

The outlook

Some recent figures on numbers of beneficiaries do not point to a cessation of rapid growth of disability expenditures. For example, Civil Service disability retirement beneficiary rolls have continued to grow. The number of beneficiaries grew by 9 percent between 1977 and 1979. Although the rate of new awards has declined in this program, it has not fallen back to a level low enough to stop the growth of the beneficiary rolls.

Despite such exceptions, the preponderance of evidence as discussed above suggests that the growth of cash payments to the disabled has slowed since 1975, and that these payments may well once again represent a stable percentage of GNP. The best prediction of their future course would also seem to be that they will remain a fairly stable proportion of GNP.

However, this prediction assumes there will be no major changes in the disability system that alter program scope, create or terminate large programs, or change benefit levels greatly from those that would be produced by indexing. In the past, as has been shown, such changes have had major effects on expenditures.

Rather than speculating on the probability of such changes, it is useful to examine a few comparisons between cash benefits on one hand, and earnings lost because of disability on the other. Unfortunately, the latest available data[11] relate to 1973–74 and thus probably underestimate current benefits somewhat, given more recent program expansion. However, at that time about one-fourth of those too disabled to work at all reported receiving no benefits, while about one-eighth received multiple benefits, not counting SSI. On average, men unable to work at all had about one-third of their earnings replaced by cash benefits.[12] Among men disabled to this extent, who were initially disabled between 1970 and 1972,[13] the percentage distribution of benefits was as follows.

Ratio of benefits to gross pre-disability earnings (inflation adjusted)	*Percent of disabled persons receiving ratio of benefits*
0 to 36	39
More than 36 to 54	25
More than 54 to 72	12
More than 72 to 90	10
More than 90	14

Whatever one regards as the appropriate measure of inadequate or excessive benefits, these figures show that both situations often occur. Thus, from a normative standpoint, there would seem to be justification for major changes in the disability system. Such changes are potentially large enough to upset the assumptions that underlie the prediction that payments will remain a fairly steady proportion of GNP. □

FOOTNOTES

[1] See Monroe Berkowitz and Jeffrey Rubin, "The Costs of Disability: Estimates of Program Expenditures for Disability, 1967–1975," Rutgers University, Bureau of Disability and Health Economics Research, 1977.

[2] In 1974, the program was federalized; data later than 1973 are not comparable.

[3] Available data on women are of little use because the question is not asked of those who report housekeeping as their primary activity.

[4] The extended analyses upon which this paper reports are contained in Jonathan Sunshine, "Disability," U.S. Office of Management and Budget, Staff Technical Paper, 1979, and "Disability: A Comprehensive Overview of Programs, Issues, and Options for Change," President's Commission on Pension Policy Working Paper, 1981.

[5] The workers' earnings series is a particularly good basis for comparison because most disability programs pay benefits to workers, and base those benefits on previous earnings. Also, as an approximation, if benefits and earnings grow at equal speed, all changes in the fraction of GNP going to disability benefits would be due to changing numbers of beneficiaries.

[6] See Raymond Eck and Edwin Hustead, "Disability Experience Under the Civil Service Retirement System—1955–1974," *Journal of Occupational Medicine*, January 1976, pp. 45–50.

A better and more direct evaluation of the medical evidence should become possible in a year or two when the National Center for Health Statistics tabulates data based on medical examinations (rather than self-reporting) which will show the incidence of heart disease and other disabling medical conditions at different dates.

[8] For example, see Monroe Berkowitz, William Johnson, and Edward Murphy, *Public Policy Toward Disability* (New York, Praeger Publishers, 1976); and Mordechai Lando, Malcolm Coate, and Ruth Kraus, "Disability Benefit Applications and the Economy," *Social Security Bulletin*, October 1979, pp. 3–10. Also see Steve Chaikind, 1979 Congressional Budget Office technical analysis paper, and John Hambor, "An Econometric Model of OASDI," Social Security Administration, Office of Research and Statistics, Studies in Income Distribution, 1979. The Lando, Coate, and Kraus paper reviews other studies.

[9] See "Compensation Systems Available to Disabled Persons in the United States," Health Insurance Association of America, 1979.

[10] Data are from the Social Security Administration 1972 Survey of Disabled and Nondisabled Adults.

[11] From the Social Security Administration 1974 Survey of Disabled and Nondisabled Adults.

[12] Again, peculiarities of the data collection methodology render the information on women of little use.

[13] These newly disabled men generally are the beneficiaries of higher real replacement ratios than men disabled earlier. Reasons for the more favored status of the recently disabled include growth, over time, in the number and scope of disability programs; receipt by the recently disabled of benefits from non-permanent sources, such as workers compensation; and less time for erosion by inflation of the real value of non-indexed benefits.